BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
MARIANNE C. BURKE, M.D.	)	File No. 05-1995-58756
Physician's and Surgeon's Certificate No. G64339	)	
Respondent.	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 10, 2003.

IT IS SO ORDERED September 10, 2003.

MEDICAL BOARD OF CALIFORNIA

By: 

Lorie G. Rice, Chair
Panel A
Division of Medical Quality

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In the Matter of the Accusation Against: **MARIANNE C. BURKE, M.D.** **1146 N. Central Ave.** **Glendale, CA 91202** **Physician's and Surgeon's Certificate Number G64339,** **Respondent.**	**Case No. 05-95-58756** **OAH No. L1998060252**

PROPOSED DECISION

This matter came on regularly for hearing on April 7, 8, 10, 11, 14, 15, 16, 17, 18 and June 17, 2003 in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Complainant, Ron Joseph ("Complainant"), was represented by E. A. Jones III, Deputy Attorney General.

Respondent, Marianne C. Burke, M.D. ("Respondent"), was present and was represented by William H. Dailey, Attorney at Law.

Oral and documentary evidence was received. The record was held open until July 31, 2003 for the parties to submit briefs in accordance with a specified briefing schedule. All briefs were timely served and filed. "Complainant's Closing Argument" was marked as Complainant's Exhibit 28 for identification. "Respondent's Closing Argument" was marked as Respondent's Exhibit "AA" for identification. "Complainant's Reply Brief" was marked as Complainant's Exhibit 29 for identification. "Respondent's Rebuttal to Complainant's Closing Argument" was marked as Respondent's Exhibit "BB" for identification. On July 31, 2003, the record was closed and the matter was deemed submitted for decision.

Respondent's argument that the Accusation and each cause for discipline alleged therein are barred by the Doctrine of Laches is rejected. A successful laches defense requires the establishment of two elements: An unreasonable delay in bringing the action, and resulting prejudice to the responding party. (Mt. San Antonio Community College District v. Public Employment Relations Board (1989) 210 Cal.App.3d 178, 258 Cal.Rptr. 302; Finnie v. Town of Tiburon (1988) 199 Cal.App.3d 1, 244 Cal.Rptr. 581, review denied.) Respondent failed to establish the requisite elements for a laches defense.

> Prejudice is never presumed; rather it must be affirmatively demonstrated by the defendant in order to sustain his burdens of proof and the production of evidence on the issue."
> Miller v. Eisenhower Medical Center (1980) 27 Cal.3d 614, 624, 166 Cal.Rptr. 826.

Respondent failed to offer any evidence that the action is barred by the statute of limitations set forth in Business and Professions Code section 2230.5 as claimed in her Amended Notice of Defense. Accordingly, that affirmative defense is rejected.

All post-hearing motions raised in the closing briefs are denied.

FACTUAL FINDINGS

The Administrative Law Judge makes the following Factual Findings:

1. Ron Joseph made the Accusation in his official capacity as Executive Director of the Medical Board of California ("the Board").

2. On October 17, 1988, the Board issued Physician and Surgeon Certificate No. G 64339 to Respondent. The license will expire on August 31, 2004 unless renewed.

3. This case involves four patients who presented at the emergency room at Medical Center of North Hollywood ("MCNH") during 1993. At all relevant times, Respondent was a physician assigned to the emergency room at that facility.

4. Respondent is a 1981 graduate of the University of Massachusetts School of Medicine and an experienced emergency room physician. Although she undertook surgical residencies at two different hospitals in Massachusetts, she did not complete either one. She became board certified in emergency medicine in June of 1994, approximately one year following the incidents referenced in the Accusation. With the exception of certain individuals with whom she worked at MCNH, Respondent has consistently enjoyed a very good professional reputation among fellow health care providers and patients.

5. The Accusation was filed with the Board on January 29, 1998. An administrative hearing was scheduled to be heard by an administrative law judge on April 17, 2000, but Respondent failed to appear at that hearing and the hearing did not go forward. On April 24, 2000, Complainant's counsel prepared a declaration and attached to that declaration the reports of Complainant's two expert witnesses and an additional letter from one of those witnesses. On May 19, 2000, the Board's Executive Director issued a "Default Decision" indicating that Respondent had waived her right to a hearing by failing to appear on April 17, 2000, and that the division would take action without further hearing based on Respondent's "admissions by way of default" and the "evidence" before it. Based on the "Default Decision," Respondent's certificate was revoked.

6. On December 28, 2001, Hon. David P. Yaffe of the Superior Court of California, County of Los Angeles, granted Respondent's petition for a writ of mandate with directions to the Board to vacate its Default Decision and "for such further proceedings as it decides to conduct." Judge Yaffe signed the Judgment on January 24, 2002 and the Clerk issued the Writ of Mandate on February 13, 2002.

Patient G.G.[1]

7. On March 27, 1993, at 6:00 p.m., patient G.G., a 43-year-old female, was brought into the emergency room at MCNH suffering from an overdose of amitriptyline (Elavil), a Schedule IV controlled substance known as a tricyclic drug. She had also ingested alcohol. Paramedics had given the patient charcoal in the field. G.G. was awake and alert, with slurred speech. She was seen by emergency room personnel at 6:05 p.m. and told them she wanted to kill herself. With a pulse rate of 146, she was tachycardic with possible tachydisrhythmia. Her blood pressure was 137/79. Respondent was the emergency room physician on duty at that time.

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[1] The patients referenced herein are referred to by their initials in lieu of their names in order to protect their privacy.

8. Nurse Paula Cicioni ("Cicioni") received the pre-hospital call. Pursuant to standard protocol, she notified the charge nurse and Respondent that a patient suffering from tricyclic overdose with alcohol was on her way in. Cicioni was involved in the patient's initial triage. She placed the patient on a monitor, called for an EKG, and took the patient's vital signs. At 6:10 p.m., Cicioni provided the relevant patient information to Respondent who told Cicioni to place G.G.'s chart in the rack. Respondent ordered laboratory tests at that time. At 6:20 p.m., G.G. was very upset, saying she wanted to "go to sleep and just die." Her blood pressure and heart rate were elevated from the time of her arrival (Blood pressure = 131/82; Pulse rate = 156.). She was found sitting at the foot of the bed with her blood pressure cuff off. A security guard and three nurses placed G.G. back in bed and G.G. was then placed in four-point leather restraints. Cicioni notified Respondent of that development and that the patient was tachycardic. Respondent "waived her off" by moving her hand in an "away" motion. At that time, a Los Angeles City police officer was present and speaking with the patient. At 6:25 p.m., G.G. was still very restless with a pulse rate of 154. At 6:55 p.m., Cicioni notified Respondent that G.G. was still thrashing in bed and confronted Respondent about her failure to attend the patient. Respondent told Cicioni that the night shift physician would see the patient when he came on duty at approximately 7:00. [2]

9. A report was given to the night shift physician between 7:05 and 7:08 p.m. The night shift physician immediately treated G.G. and had her transferred to the Intensive Care Unit.

10. Between the time of G.G.'s arrival at the hospital and the time the night shift physician came on duty, Respondent walked past G.G.'s room three times. The curtain to the room was drawn. Respondent saw the police officer's pant legs and feet, and heard speaking from behind the drawn curtain.

11. Although there were no patients in the emergency room who required more immediate care, Respondent never assessed or treated patient G.G.

12. When taken in large quantities as in this case, a tricyclic drug such as Elavil can be life threatening. Large doses of the drug affect the heart, cardiovascular system and the nervous system. A patient who has overdosed on a tricyclic can deteriorate very rapidly. Such an overdose carries with it a high potential for lethality. When alcohol is added to a tricyclic overdose, a risk of respiratory compromise exists.

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[2] Respondent spent a great deal of time attempting to discredit Cicioni with claims that, because of a personal grudge against Respondent, Cicioni falsified the medical records and was not a credible witness. All of those claims were quite unconvincing and were belied by other evidence. Cicioni was found to be both a competent and professional nurse and a credible witness. Respondent failed to establish that Cicioni falsified medical records in this (or any other) case. To the extent that Cicioni may have forgotten certain events which occurred approximately ten years ago and were collateral to the subject incident, her memory failures as to those details do not, as Respondent contends, constitute lies.

13. Because of the risk of rapid patient deterioration and possible death, the standard of care required the emergency room physician to perform an immediate assessment of the patient unless sicker patients were present. That assessment included the airway, breathing and circulation ("ABC's"). The physician must then have intervened and managed those factors before treating the remainder of the patient's symptoms. Once that was accomplished, management of the patient involved limiting the side effects of the overdose and limiting the absorption of the drug into the body. That was done by alkalinizing the blood with sodium bicarbonate or intubating the patient. Charcoal may also have been given repeatedly. Gastric lavage may have been undertaken to evacuate the stomach contents. Sorbitol may have been given to try to quicken the speed of the drug's elimination. Intubation was important to protect the airway, particularly when lavage was undertaken or charcoal was given because the patient could deteriorate very quickly resulting in seizure activity pursuant to which the patient could aspirate lavage or charcoal into the lungs. The failure of an emergency room physician to quickly assess and treat a patient suffering from a tricyclic overdose increased the patient's risk of lethality.

14. Although he testified that Respondent met the standard of care with respect to patient G.G., Respondent's expert made several key statements contradicting that opinion:

a. Ideally, every patient should be seen as soon as possible. A suicidal patient with an overdose should receive rapid care.

b. In this case, because further treatment might have been necessary, a work up was in order.

c. If lavage is going to be performed in the emergency room, it should be done relatively soon after the patient's arrival. In this case, although the patient arrived shortly after 6:00, she was not lavaged until 8:00. Albeit "not an unreasonable delay," "it could have been better and could have been worse."

d. The physician should aggressively treat a patient such as G.G., who presents with a tricyclic overdose. Such patients should have a gastrointestinal decontamination such as lavage, lavage and charcoal, or lavage and sorbitol, depending on the physician's mode of practice, because it is important to reduce the rate of absorption. Giving charcoal in the field is a good initial step. In the emergency room, there are other available options, such as lavage which removes the drug from the body. A patient with tricyclic overdose is in a dangerous situation in that he/she can decompensate very quickly. Generally, the physician should not wait for that to happen. In this case, the patient should have been seen by the physician and worked up immediately.

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15. Respondent agreed that someone with a tricyclic overdose should be aggressively treated, that part of the usual routine is lavage, and that she did not lavage GG. Today, she would ask the police officer to leave because she "wouldn't want to go through this again" and asking the officer to leave "would be more consistent with the standard of care." She would give the officer a couple of minutes to finish, but would not wait half an hour as she did.

16. Respondent's failure to assess and subsequently treat patient G.G. constituted an extreme departure from the standard of care, incompetence and general unprofessional conduct. Ordering laboratory tests and making assumptions regarding the patient's status based on the appearance of the police officer's pant legs and the sound of voices from behind a drawn curtain did not meet the standard of care in that those activities did not substitute for an immediate assessment of the patient's airway, breathing and circulation.

Patient R.S.

17. On May 22, 1993, patient R.S., a 35-year-old male HIV victim, was brought to the MCNH emergency room, arriving at 11:35 a.m.[3] R.S. had suffered a seizure and paramedics had found him prone, unresponsive to verbal stimuli and in an altered level of consciousness. He was in severe distress. The paramedics administered Valium IV, 15 mg in the field, and because stridor was heard, they inserted a nasal airway.

18. Respondent was the emergency room physician on duty when R.S. was brought in. Upon arrival, the patient's blood pressure was 140/60, his temperature was 102, his pulse rate was 129 and his respirations were 24. At 11:55, Respondent was made aware that R.S. was waking up and moving his extremities. Respondent went to the patient at that time, evaluated him and, within 30 minutes of his arrival, placed R.S. on oxygen, ordered a chest x-ray, EKG and arterial blood gasses drawn, ordered Tylenol for the fever, magnesium sulfate for the seizures and two separate doses of Versed. The test results were returned in a timely manner. At 12:10 p.m., R.S. was becoming more combative and was placed in restraints. Respondent was made aware of that development. At 12:40, Respondent was told of the patient's increasing agitation. At 12:50, the IV infiltrated and Respondent placed it at another location where it would not be affected by his agitation. At 1:00 p.m., Respondent intubated R.S. after he became less responsive and lost the protection of his airway. She ordered one gram of Rocephin and another dose of Versed shortly thereafter. The patient's vital signs then began to improve. Respondent ordered Dilantin at 2:00 p.m. to prevent additional seizures. At 2:10, the patient underwent a CT Scan. At 3:05, R.S. received the Rocephin Respondent had ordered shortly after she had intubated him. R.S. later underwent a lumbar puncture.

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[3] According to a nurse's note, the patient's time of arrival was 11:35 a.m. The Emergency Medical Service Report indicates the arrival time as 11:45 a.m. One of Complainant's expert witnesses, Marianne Gausche-Hill, M.D., credibly testified that the nurse's note is the more likely to be accurate because paramedics do not always record their time until after their tasks have been completed. Inaccuracies in those times are well discussed in EMS literature and the suggestion has been made that paramedics use stop watches or other types of technology to more accurately record the times.

19. Complainant's experts opined that Respondent failed to evaluate R.S. for 1 hour and 25 minutes after his arrival at the emergency room. They based those opinions on their review of the medical records. However, those records did not include the physician's notes. (The evidence failed to establish whether any physician's notes ever existed for R.S.) Both of Complainant's experts agreed that Respondent would have met the standard of care if Respondent evaluated the patient within minutes of her becoming aware of his presence in the emergency room.

20. Respondent was credible in her testimony that she remembered the patient, that the first notice she received was from a nurse named Marsha who told her she had a seizure patient, and that "relatively soon" but not immediately, she went to the patient and evaluated him. At that time, R.S. was coming out of a seizure but was not yet awake. That testimony corresponds to the nurse's note of 11:55 a.m., the first time the evidence indicates Respondent was made aware of the patient's presence and condition.

21. Complainant's Exhibit 26, a purported transcript of earlier statements by Emergency Room Nurse Manager, Linda Sains, and Complainant's Exhibit 13, a Declaration by Linda Sains, do not establish that Respondent failed to attend the patient for 50 minutes after her initial notification of R.S.'s presence in the emergency room because, according to those documents, Nurse Sains did not enter the room until 20 minutes after the patient was brought in. Assuming an 11:35 patient arrival time, Nurse Sains and Respondent would have entered the room at approximately the same time. If the paramedics were correct as to the time of arrival, Respondent would have seen the patient approximately ten minutes before Nurse Sains did. In either event, Nurse Sains had no first-hand knowledge of whether Respondent had previously evaluated the patient.[4]

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[4] The claims of Respondent and Ms. Sains that an attorney representing the MCNH medical staff duped or coerced Ms. Sains into giving the statements and signing the Declaration by telling her they would be used for another purpose are not well taken because (1) Ms. Sains does not deny the veracity of the statements or the Declaration, only the circumstances under which they were given, and (2) Ms. Sains was given the opportunity to make changes to her Declaration before signing it, and did indeed make one change. In any event, the statements and the Declaration are irrelevant in that, for the reason stated, they are not deemed competent evidence.

22. Complainant failed to establish, by clear and convincing evidence to a reasonable certainty, the allegations in Paragraph 4(D) of the Accusation, specifically, that (1) Respondent failed to attend to R.S. in a timely manner, thereby putting him in jeopardy of serious complications, (2) that Respondent failed to attend to R.S. within one hour of his presentation at the emergency room, thereby putting him in jeopardy of serious complications, (3) that Respondent failed to do a thorough history and physical examination in a timely manner upon R.S.'s presentation at the emergency room, and (4) that Respondent failed to begin empiric antibiotic therapy, to obtain a CT scan of the head and a lumbar puncture as appropriate upon R.S.'s presentation at the emergency room. (With respect to the last allegation, both of Complainant's experts opined that the three hour delay in the administration of the antibiotics was an extreme departure from the standard of care and they criticized Respondent for failing to follow up on her order for the antibiotic. However, Complainant does not allege in the Accusation that Respondent failed to follow up on her order. He alleged that she failed to begin empiric antibiotic therapy. Respondent did not fail to do so. She began that therapy with her timely order for Rocephin. To impose discipline for her failure to follow up on that order would constitute a denial of Respondent's due process rights.)

Patient M.F.

23. On August 14, 1993, at approximately 5:05 a.m., M.F., a 16-year-old female[5], was brought to the MCNH emergency room following a suicide attempt. M.F. was suffering from a 100-pill, multi-drug overdose. She was seen and treated by emergency room physician, Ivan Raimi, M.D. A Foley catheter, nasogastric ("NG") tube and IV were in place. Arrangements were made for M.F. to be admitted to the Intensive Care Unit by a Dr. Daniels.

24. The shift change from night shift to day shift was scheduled to occur at 7:00 a.m. and Respondent was scheduled to relieve Dr. Raimi as the emergency room physician. At approximately that time, the patient became angry. She began screaming and thrashing and she was placed in restraints. Within minutes, she had removed her Foley catheter, her IV, her NG tube and three of the four restraints. When emergency room nurses attempted to reinsert the Foley catheter, M.F. became enraged. She screamed, kicked, bit, hit, scratched and spit at the nurses as they attempted to restrain her. Six nurses were required to hold her down while they re-positioned the leather restraints. During the melee, two nurses were injured. Out of frustration, one male nurse slapped the patient with an open hand in an attempt to get her to calm down.[6]

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[5] In the Accusation, Complainant incorrectly alleged that the patient was male. The patient's correct gender was established during the hearing without prejudice to Respondent.

[6] In her Closing Argument, Respondent contends that the male nurse was "discredited . . . immediately as a professional and as a witness" by virtue of his having slapped the patient. [Exhibit "AA," page 32, lines 15-16.] That is not true. If anything, the witness's credibility was bolstered by his admission of his action and his contrition over having lost control during a difficult and stressful situation. Further, his testimony was corroborated by the testimony of other nurses who were on duty at the same time and who witnessed the same events.

25. Respondent ran uncharacteristically late that morning and, upon her arrival, heard the patient screaming. Dr. Raimi reported off to Respondent and told her the nurses were re-inserting the Foley catheter. Dr. Raimi then went off duty and Respondent became the on duty emergency room physician.

26. Albeit restrained, M.F. continued to struggle. The charge nurse approached Respondent and requested that Respondent order chemical sedation to calm the patient down. Four days before the incident, a new hospital policy went into effect as a result of a recent study on Versed. Pursuant to the new policy, the Versed was removed from the narcotic cabinet and nurses were prohibited from administering it. It remained within the physicians' discretion to order Versed, but they themselves had to administer it to the patients. Even the physicians were prohibited from ordering or administering Versed to pediatric patients. However, other drugs, such as Valium, Haldol and Atavan were available and approved for use as chemical sedation. Upon receiving the charge nurse's request for chemical sedation, Respondent answered, "Well, since Versed is my drug of choice and I'm not allowed to use it, you'll just have to call Dr. Daniels" or words to that effect. It took the charge nurse an additional 20 minutes to reach Dr. Daniels, who immediately ordered an alternative drug as chemical sedation.

27. Although there were no patients in the emergency room who required more immediate care, Respondent never saw, assessed or treated patient M.F.

28. In a case such as this, it was within the physician's discretion to decline a request for chemical sedation if the physician believed the sedating drug could have an adverse effect on a patient who had overdosed on several other drugs. The administration of chemical sedation could be particularly deleterious if the patient had ingested barbiturates. However, in this case, (1) the laboratory test results were negative for barbiturates, (2) the evidence did not indicate that Dr. Raimi suspected barbiturate ingestion at the time he reported to Respondent, and (3) Respondent did not testify she believed M.F. had ingested barbiturates. Further, Respondent's words indicate that she may have been inclined to order the chemical sedation had she been permitted to order and give Versed. It was only the fact that she was not permitted the use of that drug that caused her to decline the charge nurse's request, even though other drugs were available and medically indicated under the circumstances.

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29. Respondent's testimony that she did not hear any additional screaming after the first scream she heard on entering the emergency room is not credible in light of contrary and consistent reports from several of the nurses who were present at the time. The fact that Dr. Raimi had not sedated the patient does not excuse Respondent's conduct since the patient's status could have changed at any time. Further, Respondent claims the charge nurse's request did not make sense because the charge nurse failed to indicate anything about the patient's condition or that the nurses needed help, and said only that they needed to calm the patient down. That does not excuse Respondent's conduct either since Respondent need only have inquired as to the reason for the request in order to learn the patient's true status. In addition, M.F.'s lengthy and continued struggle against the nurses and the restraints could have resulted in her suffering rabdomyolysis, a condition that could lead to kidney failure. Therefore, Respondent should have at least inquired as to the reason for the request, and more likely, should have gone to the patient's room and assessed M.F. herself.

30. Complainant's experts agreed that Respondent deviated from the standard of care with respect to patient M.F., but disagreed as to the extent of that deviation. (In their respective reports [Exhibits 17 and 19], Dr. Gausche-Hill deemed it an extreme departure from the standard of care, but Dr. Anglin deemed it a simple departure. During the hearing, Dr. Anglin testified that Respondent's conduct "verged" on an extreme deviation from the standard of care.) Respondent's failure to order chemical sedation for patient M.F. for the reasons stated constitutes a simple departure from the standard of care and general unprofessional conduct.

Patient O.M.

31. On August 14, 1993, patient O.M., a 26-year-old male was brought to the MCNH emergency room with non-radiating epigastric pain. Respondent was the emergency room physician on duty at that time. The patient was alert and oriented. He reported that he had ingested cocaine two hours previously and had also been drinking alcohol. The patient was asymptomatic for myocardial infarction and cocaine intoxication. Respondent ordered an amylase test to rule out pancreatitis, and a urine toxicology screen to confirm cocaine use. She also ordered a "GI cocktail" consisting of antacid and analgesic, to which O.M. favorably responded.

32. In working up the patient, Respondent did not order a urinalysis or CPK to rule out rabdomyolysis. She considered ordering an EKG to rule out a myocardial infarction but decided against it because O.M. was asymptomatic for that condition.

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33. The standard of care in 1993 in a case such as this required that, after assessing the ABCs, the emergency room physician must look for the causes of the epigastric pain, taking the patient's history into account. In so doing, appropriate tests were to be ordered, including a urinalysis, CPK and EKG since, following cocaine ingestion, a myocardial infarction may manifest with only the symptom of epigastric pain. A CPK measures muscle breakdown from the heart or other muscles. An EKG records the electrical activity of the heart to determine ischemia (lack of oxygen) or other adverse effects on the heart. A urinalysis gives signs of kidney function and evidence of infection, and could raise a suspicion of muscle breakdown sometimes seen with cocaine use. O.M.'s relief from his symptoms following his taking the GI cocktail, and the fact that O.M. slept part of the time he was in the emergency room, did not rule out other serious medical conditions. By choosing not to order the urinalysis, CPK and EKG, Respondent rendered a differential diagnosis without ruling out a serious potential cause of the patient's symptoms.

34. Although he opined that Respondent met the standard of care in this case, Respondent's expert witness conceded that a patient who has ingested cocaine two hours earlier can present asymptomatically. However, the potential for ongoing myocardial ischemia remains.

35. In choosing not to order the urinalysis CPK and EKG, Respondent relied on the 1992 version of Tintinelli's emergency room text. However, neither that nor any other text establishes the standard of care in a given community at a given time. (Bailey v. Dreutzmann (1904) 141 Cal. 519, 521-522; Gluckstein v. Lipsett (1949) 93 Cal.App.2d 391, 403; Salgo v. Leland Stanford Jr. University Board of Trustees (1957) 154 Cal.App.2d 560, 579.) The standard of care is established by competent expert witness testimony. That testimony was provided by Complainant's expert witnesses, at least one of whom, as early as the 1980's, was aware of the proper protocol for ruling out rabdomyolysis and myocardial infarction in patients who had ingested cocaine. Complainant's two experts differed only on whether Respondent's failure to order an EKG constituted a simple or an extreme departure from the standard of care.

36. Respondent's failure to order a urinalysis, CPK and EKG for O.M. constitutes a simple departure from the standard of care and incompetence.

The Experts

37. Complainant offered the testimony of two expert witnesses in this case—Deirdre Anglin, M.D. and Marianne Gausche-Hill, M.D.

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38. Dr. Anglin received her medical training at the University of Ottowa. After a rotating internship, she served a residency in emergency room medicine in Montreal and then practiced emergency room medicine at the University of Alberta Hospital. She moved to the United States in 1986 and became licensed to practice in California shortly thereafter. She practiced in the emergency rooms at White Memorial Hospital and Los Angeles County/University of Southern California Medical Center (the busiest emergency department in the country) for approximately 15 years. She has taught at the University of Southern California Medical School since 1988 and was promoted to the position of Associate Professor of Emergency Medicine seven years ago based on her clinical, teaching and research skills.

39. Dr. Gausche-Hill attended the UCLA School of Medicine and performed a general surgery internship and two residencies at UCLA/Harbor Medical Center. She was certified in emergency medicine in 1987 by the American Board of Emergency Medicine and was recertified by that board in 1992. She is sub-boarded in pediatric emergency medicine. Dr. Gausche-Hill is the Director of Pediatric Emergency Medicine at Little Company of Mary Hospital and is both the former and future Director of Emergency Medical Service at Harbor/UCLA Medical Center. She is a Full Professor of Medicine at the Geffen School of Medicine at UCLA.

40. Respondent offered the expert testimony of James Allen, M.D. Dr. Allen received his undergraduate degree from Ohio State University and attended medical school in Guadalajara, Mexico. He performed an externship and a surgical and orthopedic residency at Mt. Carmel Medical Center in Columbus, Ohio where he continued to work for the next 15 years until he moved to California. Dr. Allen moonlighted as an emergency room physician during his externship and residency. He did not change his area of emphasis because there was no emergency room residency available at that time. After moving to California, Dr. Allen took 6 to 12 months off. He then worked in an emergency room in Malibu and later served as a contract physician at West Hills and various other hospitals. Dr. Allen taught interns and residents in the emergency room at Mt. Carmel Medical Center and was an Associate Professor at Ohio State University where he gave formal lectures. Dr. Allen describes himself as an "emergentologist" which he defines as a physician who works in an emergency room. He is not board certified in emergency medicine, a circumstance he attributes to there being no emergency medicine residencies available anywhere during the 1970's.

41. On balance, the credentials and qualifications of Drs. Anglin and Gausche-Hill are stronger than those of Dr. Allen and, in areas of dispute, their testimony was generally given greater weight.

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Costs

42. Pursuant to Business and Professions Code section 125.3, Complainant's counsel requested that Respondent be ordered to pay to the Board $47,313.10 for its costs of investigation and prosecution of the case. The costs consist of $14,851.10 for investigative services and expert witness fees, and $32,462.00 in Attorney General's fees.

43. Title 1, California Code of Regulations, section 1042(b) provides:

> "Unless the applicable cost recovery statute provides otherwise, evidence relating to cost recovery shall be submitted in the following manner:
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> (1) Evidence relating to costs shall be submitted by certificate executed by the agency or its designee or by affidavit.
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> (2) A certificate or affidavit in support of costs incurred by the agency for services provided by regular agency employees should include sufficient information by which the ALJ can determine the costs incurred in connection with the matter and the reasonableness of such costs, for example, a general description of tasks performed, the time spent on such tasks, and the method of calculating the cost for such services.
>
> (3) Services provided by other persons shall be supported by an affidavit executed by the provider of such services which should contain sufficient information by which the ALJ can determine the costs incurred in the matter and the reasonableness of such costs, for example, a general description of the tasks performed, the time spent on such tasks and the hourly rate or other form of compensation. In lieu of such an affidavit, the agency or its designee may attach to its certificate or affidavit copies of time and billing records upon which costs were incurred by the agency.
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> (4) For other costs incurred by the agency, the bill, invoice, or other similar document reflecting the cost incurred by the agency should be attached to the certificate or affidavit submitted by the agency or its designee.
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> (5) Where the agency seeks a cost award based on an estimate of actual costs incurred, the certificate or affidavit should explain the unavailability of actual cost information.

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(6) The ALJ may, at his or her discretion, permit any party to present testimony relevant to the imposition and reasonableness of costs."

Business and Professions Code section 125.3 states in relevant part:

"(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge where the proposed decision fails to make a finding on costs requested pursuant to subdivision (a)."

Government Code section 11425.50(c) states:

"The statement of the factual basis for the decision shall be based exclusively on the evidence of record in the proceeding and on matters officially noticed in the proceeding. The presiding officer's experience, technical competence, and specialized knowledge may be used in evaluating evidence."

Expert Witness Fees

44. Complainant seeks recovery of $11,513.05 in expert witness fees for "reviewing and evaluating case-related materials, report writing, hearing preparation and examinations." That sum reflects work performed by both expert witnesses totaling 16 hours in October and November of 1997 and 93 hours in June, July and August of 1999, all at an hourly rate of $75.00.

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45. The only evidence of the expert witness fees is a list in a Declaration by Marc Gonzalez, Supervising Investigator for the Board's Woodland Hills District Office. The list references the date the fees were incurred, the number of hours spent on each such date, the hourly rate, the total fees incurred on each date and the "service" provided. For each entry on the list, the "service" is listed as "record review." Neither Mr. Gonzalez's Declaration nor the list provided therein rise to the level of prima facie evidence of reasonableness as defined in Business and Professions Code section 125.3(c). Rather, they constitute only evidence that the costs were incurred.

46. Dr. Gausche-Hill wrote her report in November of 1997. Dr. Anglin wrote her report in September of 1999. Even assuming that both experts engaged in a record review in 1999 in preparation for the April 2000 trial, it is still difficult to reconcile the vast discrepancy in the number of hours spent in 1999 as opposed to 1997. For example, even if each expert spent 15 hours preparing for trial, that would leave 63 hours spent by Dr. Anglin for her initial record review and report writing, in contrast to Dr. Gausche-Hill's having spent 16 hours on virtually identical tasks. (This gives Complainant the benefit of the doubt that all of the 1997 hours were incurred by Dr. Gausche-Hill.) Absent other evidence to justify that discrepancy, Dr. Anglin should have been able to complete her initial record review and report writing in approximately the same time taken by Dr. Gausche-Hill. The difference between Dr. Anglin's 63 hours and Dr. Gausche-Hill's 16 hours is 47 hours. Those 47 hours are deemed excessive and shall be disallowed.

Set-off for Unproven Matters

47. Complainant sustained his burden of proof with respect to only three of the four patients referenced in the Accusation. He is therefore not entitled to all of the awardable costs and fees.

48. However, the costs and fees are not broken down according to which ones were incurred in connection with the specific issues referenced in the Accusation. While there is no statutory or regulatory requirement that they be broken down in that manner, absent such a division, the reasonableness of the cost bill may be determined using a percentage of the costs, based upon the number and complexity of the proven issues.

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49. In this case, Complainant did not sustain his burden of proof with respect to patient R.S. The issues relating to that patient appear to be approximately average in terms of complexity and time consumption as compared with those involving the other three patients. (For example, two non-party percipient witnesses were involved in R.S.'s part of the case while only one was involved with respect to patient G.G. and several were involved with respect to patient M.F.) On that basis, the Administrative Law Judge deems a sum approximately equivalent to 75% of the total awardable costs to be the reasonable amount of costs recoverable in this case.

Total

50. The total cost bill is reduced by $3525 (47 hours @ $75.00/hour), leaving a new total of $43,788.10. That sum is further reduced by 25% as a set-off for the unproven matters. Complainant shall be awarded costs totaling $32,841.08.

LEGAL CONCLUSIONS

Pursuant to the foregoing Factual Findings, the Administrative Law Judge makes the following legal conclusions:

1. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234(b), for gross negligence, as set forth in Findings 7 through 16.

2. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234(c), for repeated negligent acts, as set forth in Findings 7 through 16, and 23 through 36.

3. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234(d), for incompetence, as set forth in Findings 7 through 16 and 31 through 36.

4. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, for general unprofessional conduct, as set forth in Findings 7 through 16 and 23 through 30.

5. Cause exists to order Respondent to pay the costs claimed under Business and Professions Code section 125.3, as set forth in Findings 42 through 50.

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Respondent is found to have engaged in acts of gross negligence, simple negligence and incompetence. Gross negligence is defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (Gore v. Board of Medical Quality Assurance (1970) 110 Cal.App.3d 184, 195-198.) Simple negligence reflects a departure from the standard of care to a lesser degree. In Kearl v. Board of Medical Quality Assurance (1986) 189 Cal.App.3d 1040, 236 Cal.Rptr. 526, the Court distinguished incompetence from negligence as follows:

> "The term 'incompetency' generally indicates 'an absence of qualification, ability or fitness to perform a prescribed duty or function.' (Pollack v. Kinder (1978) 85 Cal.App.3d 833, 837.) Incompetency is distinguishable from negligence, in that one 'may be competent or capable of performing a given duty but negligent in performing that duty.' (Id, at p. 838.) Thus, "'a single act of negligence ... may be attributable to remissness in discharging known duties, rather than ... incompetency respecting the proper performance."' (Ibid, quoting from Peters v. Southern Pacific Co. (1911) 160 Cal. 48, 62 [116 P. 400].) The Pollack court concludes: 'While it is conceivable that a single act of misconduct under certain circumstances may be sufficient to reveal a general lack of ability to perform the licensed duties, thereby supporting a finding of incompetency under the statute, we reject the notion that a single, honest failing in performing those duties--without more--constitutes the functional equivalent of incompetency justifying statutory sanctions.' (85 Cal.App.3d at p. 839, italics in original.)"
> (Id. at 1054-1055.)

Respondent's Contentions

In addition to her denials of gross negligence, simple negligence, incompetence and general unprofessional conduct, throughout the proceedings, Respondent emphasized certain arguments that bear discussion in this Proposed Decision. The order in which they are addressed below does not reflect on their importance or emphasis.

1. Respondent argues that the entire action was tainted and prejudicial against her because it arose out of an intra-hospital, politically-motivated peer review procedure which the Board accepted at face value despite "tomes of factual evidence and testimony to the contrary." (Ex "AA"—Respondent's Closing Argument, page 39, lines 15-16.)

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Regardless of what may have prompted the Board to file the Accusation, the only evidence considered by the Administrative Law Judge was that admitted, either without or over objection, at the hearing.[7] The vast majority of the evidence consisted of patients' medical records, expert witness reports, and the like, which were independently admissible at the administrative hearing. The relevant testimony was based on the witnesses' knowledge relating to the incidents regarding one or more of the four patients referenced in the Accusation, and not on what occurred during the peer review procedure. To the extent they were even mentioned during the administrative hearing, any findings made during the peer review proceedings were deemed irrelevant in that they carry no precedential effect and may have been based on evidence other than that received during the administrative hearing. Put succinctly, the procedures and findings relating to the peer review, to the small extent that they may have been raised in the administrative hearing, were and are deemed irrelevant for purposes of the findings, conclusions and order herein.

The evidence did not disclose the extent, if any, to which the expert witnesses relied on matters relating to the peer review in forming their respective opinions. However, to the extent that the experts may have relied on information that was inadmissible at trial, their testimony is nonetheless deemed admissible pursuant to Evidence Code sections 801(b) and 803.

2. Respondent argued that the Board exhibited bias and prejudice against her in its investigation, filing of the Accusation, earlier "default" revocation, litigation regarding the "default" revocation, and prosecution of this matter. In order to establish a defense of discriminatory enforcement, Respondent had to prove (1) she had been intentionally singled out for prosecution based on an invidious criterion and (2) the discriminatory design of the prosecuting authorities was the sole reason for the prosecution.

> "There must be discrimination and that discrimination must be intentional and unjustified and thus 'invidious' because it is unrelated to legitimate law enforcement objectives, but the intent need not be to 'punish' the defendant for membership in a protected class or for the defendant's exercise of protected rights." Baluyut v. Superior Court (1996) 12 Cal.4th 826, 833.

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[7] Both parties offered a small amount of evidence which may have been subject to an objection pursuant to Evidence Code section 1157, but no such objections were made. Even some of that evidence was not considered on other grounds. For example, see the discussion at paragraph 21, above, regarding patient R.S.

Respondent failed to prove the criteria for a finding of discriminatory enforcement in that she failed to establish either an "invidious criterion" which formed the basis for the Board to single her out for prosecution, or that the Board's purported discrimination against Respondent was the sole reason for the prosecution. On the contrary, causes for discipline exist with respect to three of the four patients referenced in the Accusation. Those causes for discipline were found to exist absent consideration by the Administrative Law Judge of any intra-hospital politics that may have existed a decade ago, and independent of any ulterior motives the Board may be harboring against Respondent. Respondent was afforded a full opportunity to litigate both the merits of her case[8] and the issue of the Board's alleged bias and prejudice against her. Her argument that the Accusation was completely unmeritorious and borne of bias, prejudice and improper investigation was not convincing.

Absent a showing of discriminatory enforcement, whether politics were at work at the hospital or the Board is irrelevant for purposes of this administrative proceeding. The only issues before the Administrative Law Judge are whether Respondent was grossly negligent, incompetent, committed repeated negligent acts or engaged in unprofessional conduct. Even if the Peer Review was the result of inter-hospital politics and was incorrectly evaluated by the Board in deciding to pursue the Accusation, the allegations Complainant proved at the administrative hearing were supported by competent evidence and testimony, and were proven by clear and convincing evidence to a reasonable certainty.

3. In addition to the incorrect gender referenced with respect to patient M.F., the Accusation contained other factually incorrect allegations. Those allegations did not mislead Respondent to her prejudice in putting on her defense and all of the allegations were fully and fairly litigated on their merits. Accordingly, they are not deemed material variances between the pleading and proof. (Cooper v. Board of Medical Examiners (1975) 49 Cal.App.3d 931, 943; Franz v. Board of Medical Quality Assurance (1982) 31 Cal.3d 124, 144.)

4. Respondent argues that, out of the hundreds of patients she treated at MCNH, the Board found only four patients to form the basis of the Accusation. Although cause for discipline found with respect to only a few patients in an otherwise distinguished career may have a mitigating effect on the discipline imposed, nothing in the Medical Practice Act or the case law requires Complainant to establish cause for discipline with respect to a certain minimum number of patients before discipline may be imposed. On the contrary, discipline may be imposed pursuant to Business and Professions Code sections 2227 and 2234 for conduct in connection with only one patient. Even discipline pursuant to section 2234(c), for repeated negligent acts, requires only two acts, but not two patients. (Zabetian v. Medical Board (2000) 80 Cal.App.4th 462, 94 Cal.Rptr.2d 917.)

[8] In fact, Respondent's expert witness was permitted to give his full testimony over Complainant's objection, despite the fact that Respondent's counsel failed to timely disclose the expert's identity and provide the expert's curriculum vitae to Respondent's counsel by a scheduled deadline pursuant to the court's Pre-Hearing Conference Order.

5. Respondent correctly argues that none of the patients referenced in the Accusation was injured or sustained any damage as a result of her conduct. Albeit fortuitous, it is not dispositive. Patient harm is not required for discipline of a medical certificate to be imposed. (Kearl v. Board of Medical Quality Assurance, supra, at 1053.) However, the absence of patient harm may also serve as a mitigating factor in determining the nature and extent of the disciplinary order.

Discipline Considerations

As to the four patients referenced in the Accusation, Respondent is found to have engaged in acts of gross negligence with respect to one patient, acts of simple negligence with respect to two patients, incompetence with respect to two patients and general unprofessional conduct with respect to two patients. The incidents which gave rise to the causes for discipline occurred between March and August of 1993, approximately 10 years ago.

As stated above, the Accusation was filed in 1998 and was set for trial in April of 2000. The following month, Respondent's certificate was revoked following her failure to appear at the trial. It was not until December of 2001 that the Superior Court granted Respondent's petition for Writ of Mandate, and the actual writ did not issue until February of 2002. As a result, Respondent's certificate remained revoked for almost two years.

Any disciplinary effect the revocation or suspension of Respondent's certificate might now have on Respondent's ability to practice medicine and her attitude toward her profession was surely accomplished by the revocation in 2000 and her removal from the practice of medicine for almost two years. That period of non-practice most probably had a significant *in terrorem* effect on Respondent as well, such that she has learned valuable lessons with respect to the practice of emergency medicine and the manner in which she engages in that practice. That *in terrorem* effect and the lessons Respondent learned were reflected in her testimony at trial.

Even without the earlier revocation, the findings and conclusions following this administrative hearing do not warrant an outright revocation and, absent the earlier revocation, a stayed revocation and a period of probation under proper terms and conditions would constitute an appropriate disciplinary order. However, in this case, the earlier revocation did indeed occur and little, if anything, more can be gained by further precluding Respondent's ability to practice her profession. That notwithstanding, the purpose of disciplinary actions is primarily to protect the public [Business and Professions Code section 2229(a); Handeland v. Department of Real Estate (1976) 58 Cal.App.3d 513, 518] and, secondarily, to aid in the rehabilitation of the licensee [Business and Professions Code section 2229 (b) and (c)]. The purpose of a disciplinary proceeding is not to punish the licensee [Camacho v. Youde (1979) 95 Cal.App.3d 161, 164].

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With those priorities in mind, caution must be taken to ensure that Respondent's lengthy period of non-practice has not resulted in some deterioration of her clinical skills.[9] Therefore, Respondent shall be required to take and successfully complete a clinical training program such as the Physician Assessment and Clinical Education Program ("PACE") at the University of California at San Diego School of Medicine, and shall also be required to take and pass the Special Purpose Examination ("SPEX") of the Federation of State Medical Boards. In order to ensure that Respondent takes and successfully completes the clinical training program and the SPEX, she must be placed on probation, the successful completion of the clinical training program and the SPEX must be made conditions of probation, and Respondent's failure to successfully complete those conditions in a timely manner must be deemed a violation of probation. However, once those two conditions are satisfied, regardless of when they are satisfied, continued probation will serve no further purpose and shall be terminated.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. G64339, issued to Respondent, Marianne C. Burke, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years or until the successful completion of Conditions 9 and 10 below, whichever occurs first, upon the following terms and conditions.

1. Within 15 days after the effective date of this decision, Respondent shall provide the Division, or its designee, proof of service that Respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent or **at any other facility where Respondent engages in the practice of medicine** and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to Respondent.

2. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

3. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

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[9] This is true whether or not the Board's imposed period of non-practice was justified. No finding is made in that regard, that finding having already been made by the Superior Court.

4. Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of her addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code Section 2021(b).

5. Respondent shall, at all times, maintain a current and renewed physician and surgeon license.

6. Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

7. Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

8. In the event Respondent should leave California to reside or to practice outside the State or for any reason should Respondent stop practicing medicine in California, Respondent shall notify the Division or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which Respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. A Board ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary order.

9. Within 90 days of the effective date of this decision, Respondent shall submit to the Division or its designee for prior approval, a clinical training or educational program. The exact number of hours and specific content of the program shall be determined by the Division or its designee. Respondent shall successfully complete the training program and may be required to pass an examination administered by the Division or its designee related to the program's contents. Failure to take and successfully complete the clinical training or educational program shall constitute a violation of the probation order.

10. Within 60 days of the effective date of this decision, or as soon thereafter as feasible, petitioner shall take and pass the Special Purpose Examination (SPEX) of the Federation of State Medical Boards. Failure to take and pass the SPEX within the allotted time shall constitute a violation of the probation order, unless the Board agrees in writing to a later time. Should such an agreement be made, failure to take and pass the SPEX within the agreed upon time shall constitute a violation of the probation order.

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11. If Respondent violates probation in any respect, the Division, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against Respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. Respondent is hereby ordered to reimburse the Division the amount of $32,841.08 within 90 days from the effective date of this decision for its investigative and prosecution costs. Failure to reimburse the Division's costs of its investigation and prosecution shall constitute a violation of the probation order, unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by Respondent shall not relieve Respondent of her responsibility to reimburse the Division for its investigative and prosecution costs.

13. Respondent shall pay the costs associated with probation monitoring each and every year of probation. Such costs shall be payable to the Division of Medical Quality and delivered to the designated probation surveillance monitor no later than January 31 of each calendar year. Failure to pay such costs within 30 days of the due date shall be considered a violation of probation.

14. Following the effective date of this decision, if Respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may voluntarily tender her certificate to the Board. The Division reserves the right to evaluate Respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, Respondent will no longer be subject to the terms and conditions of probation.

15. Upon successful completion of probation or successful completion of the clinical training program and SPEX, whichever occurs first, Respondent's certificate shall be fully restored.

DATED: August 21, 2003

H. Stuart Waxman

H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 05-95-58756
MARIANNE C. BURKE, M.D. 1146 N. Central Ave. Glendale, Ca. 91202	**ACCUSATION**
Physician and Surgeon's Certificate No. G64339,	
Respondent.	

The Complainant alleges:

PARTIES

1. Ron Joseph ("Complainant") brings this accusation solely in his official capacity as the Executive Director of the Medical Board of California (hereinafter the "Board").

2. On or about October 17, 1988, Physician's and Surgeon's Certificate No. G64339 was issued by the Board to Marianne C. Burke, M.D. (hereinafter "respondent"). At all times relevant to the charges brought herein, this license has been in full force and effect. Unless renewed, it will expire on August

31, 1998.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the Business and Professions Code (hereinafter "Code"):

A. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have her license revoked, be suspended for a period not to exceed one year, be placed on probation and required to pay the costs of probation monitoring, or have such other action taken in relation to discipline as the Division deems proper.

B. Section 2234 of the Code provides that unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

C. Section 125.3 of the Code which, in relevant part, provides:

"(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

"(b) . . .

"(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General."

D. Section 16.01 of the 1997/1998 Budget Act of the State of California provides, in pertinent part, that:

"(a) No funds appropriated by this act may be expended to pay any Medi-Cal claim for any service

performed by a physician while that physician's license is under suspension or revocation due to disciplinary action of the Medical Board of California.

"(b) No funds appropriated by this act may be expended to pay any Medi-Cal claim for any surgical services or other invasive procedure performed on any Medi-Cal beneficiary by a physician if that physician has been placed on probation due to a disciplinary action of the Medical Board of California related to the performance of that specific service or procedure on any patient, except in any case where the board makes a determination during its disciplinary process that there exist compelling circumstances that warrant continued Medi-Cal reimbursement during the probationary period."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

4. Respondent Marianne C. Burke, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code in that respondent was grossly negligent in the care, treatment and management of four patients. The circumstances are as follows:

(Patient G.G.[1])

A. On or about March 27, 1993, G.G., a 43 year old female, was brought into the Emergency Room at the Medical

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1. All patient references in this pleading are by initials only. The true names are known to respondent and will be provided to her upon her timely written request for discovery pursuant to Government Code section 11507.6.

Center of North Hollywood by paramedics. G.G. had ingested an excessive dosage of amitriptyline (Elavil), a Schedule IV controlled substance and dangerous drug. Respondent, who was the emergency room physician on duty at that time, was advised of G.G.'s presence and her drug overdose condition. Respondent did not attend to the patient. Respondent continued not to attend to and did not see the patient despite again being advised that the patient had overdosed on Elavil, that the patient was thrashing in her bed, and that the patient had been placed in restraints to avoid injury to herself and to the emergency room staff. Respondent, instead, informed the emergency room nurses that "the night shift physician will see the patient." Eventually, but fifty-five minutes after being brought into the emergency room, G.G. was seen by the emergency room physician who, at 7:00 p.m., relieved respondent. The night shift emergency room physician attended to G.G. almost immediately after coming on duty.

B. Respondent's acts and omissions to act during the care, treatment and management of patient G.G., who was in a critical state at the time she was brought into the emergency room where respondent was on duty and in charge, were extreme departures from the standard of care, as follows:

(1) On or about March 27, 1993, respondent failed to attend to G.G. in a timely manner, thereby causing patient G.G. to suffer further toxicity from the drugs ingested and putting patient G.G. in jeopardy of fatal complications.

(2) On or about March 27, 1993, respondent failed to intubate patient G.G. in a timely manner.

(3) On or about March 27, 1993, respondent failed to administer charcoal and cathartics to patient G.G. in a timely manner.

(4) On or about March 27, 1993, respondent failed to evaluate patient G.G. for the need for alkalinization of her blood in a timely manner.

(Patient R.S.)

C. On or about May 22, 1993, R.S., a 35 year old male, was brought into the Emergency Room at the Medical Center of North Hollywood. Respondent was the emergency room physician on duty at the time. R.S., who was HIV positive, presented cerebral toxoplasmosis and a 102 degree fever. R.S. had experienced a grand mal seizure and was given Valium, a Schedule IV controlled substance and dangerous drug, intravenously en route to the emergency room. R.S. arrived at the emergency room at 11:35 A.M. but was not seen by respondent until 12:50 P.M., one and one-quarter hours later, when he, R.S., suffered respiratory failure. Prior to being seen by respondent, R.S. experienced a second grand mal seizure. Respondent ordered that the patient be given Versed, a Schedule IV controlled substance and dangerous drug, without having seen or examined the patient.

D. Respondent's acts and omissions to act during the care, treatment and management of patient R.S., who was in a critical state at the time he was brought into the emergency

room where respondent was on duty and in charge, were extreme departures from the standard of care, as follows:

(1) On or about May 22, 1993, respondent failed to attend to patient R.S. in a timely manner, thereby putting patient R.S. in jeopardy of serious complications.

(2) On or about May 22, 1993, respondent failed to attend to patient R.S. within one hour of his presentation at the emergency room, thereby putting patient R.S. in jeopardy of serious complications.

(3) On or about May 22, 1993, respondent failed to do a thorough history and physical examination in a timely manner upon patient R.S.'s presentation at the emergency room.

(4) On or about May 22, 1993, respondent failed to order appropriate laboratories and cultures in a timely manner upon patient R.S.'s presentation at the emergency room.

(5) On or about May 22, 1993, respondent failed to begin empiric antibiotic therapy, to obtain a CT scan of the head and a lumbar puncture as appropriate upon patient R.S.'s presentation at the emergency room.

(Patient M.F.)

E. On or about August 14, 1993, M.F., a 16 year old male, was brought into the Emergency Room at the Medical Center of North Hollywood on a multi-drug overdose. Because the patient was agitated and combative, the nurses on duty

requested that respondent, the emergency room physician on duty at the time, order chemical sedation. Respondent refused, stating that it was not her responsibility. The patient continued in his agitated and combative state and injured several nurses who tried to restrain him.

F. Respondent's acts and omissions to act during the care, treatment and management of patient M.F., who was in a critical state at the time he was brought into the emergency room where respondent was on duty and in charge, were extreme departures from the standard of care, as follows:

(1) On or about August 14, 1993, respondent failed to order chemical sedation for patient M.F. to address the patient's combative behavior.

(Patient O.M.)

G. On or about August 14, 1993, patient O.M., a 26 year old male, was brought into the Emergency Room at the Medical Center of North Hollywood. Respondent was the emergency room physician on duty at the time. Although the patient reported having smoked cocaine two hours prior to being taken the emergency room and was experiencing abdominal pain, respondent did not order an EKG. Although a urine toxicology screen was sent, no urine or CPK was sent to ascertain whether patient O.M. had evidence for rhabdomyolysis.

H. Respondent's acts and omissions to act during the care, treatment and management of patient O.M., who was in a critical state at the time he was brought into the emergency

room where respondent was on duty and in charge, were extreme departures from the standard of care, as follows:

(1) On or about August 14, 1993, respondent failed to order a diagnostic test--specifically, an EKG--which was necessary to determine that patient O.M. had not sustained a further serious complication--namely, myocardial infarction--because of his drug use.

(2) On or about August 14, 1993, respondent failed to order diagnostic tests--specifically, urine or CPK --to ascertain whether patient O.M. had evidence for rhabdomyolysis because of his drug use.

SECOND CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

5. Respondent Marianne C. Burke, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code in that respondent was repeatedly negligent in the care, treatment and management of four patients. The circumstances are as follows:

A. Complainant refers to and, by this reference, incorporates herein the allegations contained in paragraph 4, subparagraphs A through H, inclusive, above, as though fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

6. Respondent Marianne C. Burke, M.D. is subject to disciplinary action for unprofessional conduct under section 2234, subdivision (d), of the Code in that respondent has demonstrated a

lack of knowledge or inability to carry out her responsibilities as a physician and surgeon, as follows:

A. Complainant refers to and, by this reference, incorporates herein the allegations contained in paragraph 4, subparagraphs A through H, inclusive, above, as though fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

7. Respondent Marianne C. Burke, M.D. is subject to disciplinary action for unprofessional conduct under section 2234 of the Code in that respondent failed to treat patients in a timely manner or abandoned patients, as follow::

A. Complainant refers to and, by this reference, incorporates herein the allegations contained in paragraph 4, subparagraphs A through H, inclusive, above, as though fully set forth.

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number G64339, heretofore issued to respondent Marianne C. Burke, M.D.;

2. Revoking, suspending or denying approval of respondent's authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering respondent to pay the Division the

reasonable costs of the investigation and enforcement of this case and, if placed on probation, the costs of probation monitoring;

4. Taking such other and further action as the Division deems necessary and proper.

DATED: January 29, 1998.

Ron Joseph
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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